Self-Harm and Moral Codes in Emergency Departments in England

Abstract

This article uses a theory of 'moral codes' to analyse the treatment of non-fatal self-harm in emergency departments in the NHS in England. It argues that self-harm has historically been the object of various moral classifications ranging from criminality, to immorality, to mental illness. In the contemporary situation these classifications are highlighted in two areas of health and social policy: first, in terms of the implementation of the National Institute of Health and Care Excellence's clinical guideline on self-harm; second, in terms of the application of section 136 of the 1983 Mental Health Act to individuals who self-harm or who are at risk of self-harm and are brought to emergency departments by the police. The main influences upon the theoretical framework employed are Durkheim, Parsons, especially his concept of the sick role, and Alexander.

Keywords: **emergency departments, moral codes, moral relativism, self-harm, sick role**

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1. Introduction

This article uses a theory of 'moral codes' to analyse the treatment of individuals with mental health conditions[1] in health institutions in England. It focuses upon one such condition, non-fatal self-harm, and analyses its treatment in accident and emergency departments (EDs)[2] in the National Health Service (NHS). EDs are selected for analysis because they deal with high statistical rates of self-harm which elicit specific social reactions from health care staff. Self-harm is here defined, following the National Institute of Health and Care Excellence (NICE) as 'acts of intentional self-poisoning or self-injury irrespective of type of motivation' (2011, p. 5) and this includes taking an overdose of medication (self-poisoning) and the cutting of the body with a sharp object (self-injury). The source material for this analysis includes sociological research, epidemiological and clinical studies, health and social policy documents, and literature emanating from the service user, or 'survivor' social movement (for example, the National Self-Harm Network [NSHN], 2000).

Moral code theory draws upon a sociological tradition that began with Durkheim (1926), includes Parsons (1951), especially his concept of the sick role, and has its most recent rendition in Alexander's (2006) cultural sociology. The theory asserts that mental health conditions are surrounded by moral attitudes and values which are expressed in social reactions to that condition. Stated as a group of middle-range concepts (Merton, 1949, pp. 39-53), moral codes have five components which structure the social interactions between individuals and

[1] The term 'mental health condition' is used in this article to refer to a wide range of mental illnesses, disorders and symptoms.

[2] Accident and emergency departments will be referred to as emergency departments and abbreviated to EDs for the rest of this article.

what Parsons called ‘therapeutically oriented health service agencies’ (1975, p. 257). The five components are: 1) a set of *rules*, which may be written or unwritten; 2) the use of linguistic *labels* to classify individual behaviour; 3) the attribution of the *sick role* as a means of legitimising such behaviour; 4) *punishments* (verbal and/or physical) when the legitimisation of the sick role is denied; and 5) *progressive* elements, which promote relationships of solidarity between healthcare staff and individuals in need.

Although moral code theory is intended as a general theory of social reactions to mental health conditions, it is also meant to ‘guide empirical inquiry’ (Merton, 1949, p. 39), in the case considered here, an analysis of social reactions to self-harm in EDs. That analysis occupies the main part of this article. Before that there are two preliminary sections. The first outlines the deeper theoretical influences of moral codes; the second provides some basic statistical facts about self-harm and EDs. The subsequent analysis of self-harm then proceeds in two stages: first, by using the five middle-range concepts outlined above; second, by focussing on two contemporary features of that analysis and engaging them with the deeper theoretical influences outlined in the next section. These two features are: 1) NICE’s clinical guideline 16 (cg16) (2004) on the ‘short-term management’ of self-harm in EDs; and 2) the interaction between section 136 (s136) of the 1983 *Mental Health Act* (MHA) and mental health professionals in EDs tasked with the assessment of individuals who have self-harmed, or are at risk of self-harm, and have been detained under that section.

2. Moral Code Theory

The three main influences on moral code theory are Durkheim, Parsons and Alexander. From Durkheim, the theory adopts the ontology that society is constituted of moral norms and values which can be epistemologically detected through the study of ‘social facts’ (Durkheim, 1964). These facts consist of the sorts of phenomena represented by the five middle-range concepts

outlined above and, in addition, historical tendencies manifested, for example, in statistical data. Where self-harm is concerned, the theory stresses its moral status, the fact that historically it has been legally proscribed, and the ongoing research programmes which advance knowledge of it. As was the case for Durkheim (1966) with suicide, the facts revealed by psychiatric epidemiology are treated as not just scientific but also moral; through statistical correlations and tendencies they provide information about social strains and the effects of these strains on patterns of social solidarity. So, for example, when the Multi-Centre Study on Self-Harm in England revealed an increase in rates of self-harm in the aftermath of the 2008 economic recession (Hawton *et al,* 2016), moral code theory interprets this fact along Durkheimian lines as expressing a variation in norms and values in a way that is similar to the effects of such recessions upon suicide rates (for example, Barr *et al*, 2012). Also from Durkheim (1992), the theory adopts a morally relativistic approach to social deviance: human behaviours classified as deviant elicit various labels ranging from immorality to criminality to mental illness. Self-harm is an apt example of relativistic moral classification in that until the *Suicide Act* of 1961,which decriminalised suicide in England and Wales, it was classified as a criminal offence, having being interpreted during the previous historical era as 'attempted suicide' (see Cresswell and Karimova, 2010; Millard, 2015). Since then it has been re-classified as a behaviour appropriately addressed via health-based interventions such as NICE clinical guidelines (2004, 2011) and suicide prevention programmes (HM Government, 2012).

Parsons (1951, 1964) applied Durkheim's ontology to his medical sociology. His theory of mental illness conceived of it as a form of social deviance which it was psychiatry's task to treat and rectify. Parsons was concerned with both the moral status of the medical profession and of the designated 'patient'. This is why there were two roles attached to the sick role: the sick role itself and the 'therapeutic role' and they were meant to function in a complementary way – at least when the interactions between them ran smoothly. Parsons has been correctly

critiqued for failing to account for the malfunctioning of the sick role, for example in cases of chronic rather than acute illness (Charmaz and Rosenfeld, 2009) and also in terms of mental health conditions rather than physical illness (Busfield, 1996, pp. 62-64). However, moral code theory accepts these critiques and in its empirical analyses emphasises the sick role's malfunctioning as well as its functioning. The concept of the sick role itself is retained because of its moral ontology (see Shilling, 2002; Varul, 2010) and because of its usefulness for explaining the treatment of individuals who self-harm. Parsons also retained Durkheim's moral relativism. In particular, he noted the tendency for Western societies to classify 'more and more types of deviance under an illness label' (Gerhardt, 1989, p. 12) so that medical treatment and psychotherapy replaced censure or punishment as the social reactions of choice. However, in keeping with an emphasis upon the sick role's malfunctioning, this tendency is sometimes reversed in EDs in the case of self-harm; in other words, self-harm, which can be classified as a mental health condition and often is, sometimes gets re-classified as immorality instead. Such re-classifications are significant for understanding the treatment of individuals who self-harm and attend EDs.

The final aspect of moral code theory is Alexander's cultural sociology. It is from Alexander that the 'code' aspect of moral code theory is derived. Although his modifications of Durkheim and Parsons are extensive, the elements to emphasise here are symbolic and cultural. Alexander stressed the autonomy of a cultural realm consisting of linguistic and non-linguistic signs which are represented through systems of symbolic classification (Alexander and Smith, 2002). Symbolic classifications form into codes the meanings of which can be decoded through the study of specific institutions – through quantitative, qualitative, and historical research. One feature of such codes for Alexander is that they tend to take binary forms; the examples from Durkheim (1926) are the 'sacred' and the 'profane'; and from Alexander (2002) himself, 'good' and 'evil'. The chief binary code that has been applied to individuals who self-harm in

EDs is that of the 'good patient' and the 'bad patient' in the context of applying the sick role, although research also reveals variations around that binary theme. One such variation concerns the way in which the 'bad patient' branch of the binary code itself tends to bifurcate into behaviour classified as either immoral and/or criminal. Another variation concerns an additional bifurcation depending upon whether the act itself is a single event or the most recent episode in a repetitive sequence of self-harming acts. In these latter cases, the tendency has been for an alignment to occur between single acts of self-harm and the classification of the 'good patient' and a separate alignment to occur between repetitive acts of self-harm and the classification of the 'bad patient'. It is to this binary coding of the 'good patient' and the 'bad patient' and its variations that the article next turns beginning with some statistical facts.

3. Self-Harm and Emergency Departments (EDs) in England

It has long been recognised that self-harm is a major reason for attendance at EDs. Current estimates from the Multi-Centre Study on Self-Harm in England suggest a total number of attendances per year of at least 200 000 (Clements *et al*, 2016, p. 1). Of these, the majority are for self-poisoning (some studies suggest up to 90 per cent) followed by self-injury (Carroll et al, 2014, p. 5). Demographically, whilst females are in the majority (about 60 per cent) there are still significant numbers of males who self-harm (about 40 percent) (see Geulayov, 2016). In terms of age, whilst the largest number of self-harm episodes are found in the 15-24 age group (about 40 per cent) there are also significant numbers of older self-harmers (*ibid*.).

Two issues have dominated the research literature and are particularly relevant for this article: first, the relation of non-fatal self-harm to eventual suicide; second, the repetition of self-harm and subsequent re-attendance at EDs. Regarding the former, current estimates suggest that, 'half of all people who die by suicide have previously self-harmed', and that, 'the rate of suicide in the self-harm patient population is up to a 100 times higher than that of the general

population' (Carroll *et al*, 2014, p.). With regard to the likelihood of the repetition of self-harm after a first episode and re-attendance at an ED, the proportion has been estimated to be 21 per cent (Geulayov et al, 2016, p. 6.). Significantly, and despite public health interventions since the millennium, Carroll et al noted in 2014 that, 'the incidence of repeat self-harm and suicide is no lower…than in studies conducted over 14 years ago' (p. 7). Attendance at an ED for self-harm remains, therefore, a significant risk factor for both repetition of self-harm and future suicide.

These statistical facts contextualise the following analyses. The next section is organised in terms of the five components of middle-range moral code theory outlined in the introduction.

4. The Moral Code in Emergency Departments (EDs)

The centrality of the sick role for understanding the moral code of self-harm arises from the fact that it presents to EDs primarily as a medical emergency. It demands an immediate reaction from doctors and nurses. The question of the attribution of the sick role and the legitimacy of the individual's presenting condition, therefore, arises at once. This was the theme of a key text of research on moral codes and self-harm in EDs: Jeffery's 1979 ethnography, 'Normal Rubbish: Deviant Patients in Casualty Departments'. Writing from a Parsonian perspective, Jeffery was the first sociologist to identify the good patient/bad patient binary code at the heart of professionals' reactions to self-harm. In particular, Jeffery made the following observations. 1) The rules which applied and were broken in EDs were mainly unwritten and stipulated that the patient: i) should not be held responsible for their illness; ii) should regard their illness as an 'undesirable state' (Jeffery, 1979, p. 101); and iii) should co-operate with medical treatment. Individuals who self-harmed potentially broke all three rules insofar as staff believed that they i) 'knew what they were doing and chose to take an overdose for their own purposes' (*ibid.*, p. 99); ii) wanted to be ill 'in order to put moral pressure on someone' (*ibid,* p. 101); and iii)

fought back ‘when a rubber tube is being forced down their throat so that their stomach can be washed out’ (*ibid.*, pp. 101-102).

2) Such rule-breaking resulted in ‘moral evaluations’ (*ibid.*, p. 91) which were ‘hostile’ (ibid, p. 104) and expressed verbally by doctors and nurses – hence the label of ‘rubbish’ in Jeffery’s title.

3) These evaluations corresponded to ‘the classic description by Parsons of the sick role’ (*ibid.*, p. 99) – except that what Jeffery witnessed was the malfunctioning as well as the functioning of the sick role: those cases were the role-complementarity between the sick role and the therapeutic role had broken down and the legitimacy which the sick role provided the individual who self-harmed was denied.

4) One consequence of illegitimacy was ‘punishment’ (*ibid.*, pp. 103-104). This took linguistic and non-linguistic forms: verbal hostility, long waiting-times and ‘vigorous treatment…most noticeable in the case of overdoses…Staff…showed no sympathy for the victim’ (*ibid.*).

5) Jeffery’s description of such punishment was grim. It revealed little solidarity in the relationships between staff and those who self-harmed. On the other hand, not all individuals who self-harmed were punished. Some legitimately occupied the sick role and were therefore classified as ‘good’ patients rather than ‘rubbish’. The difference depended on two factors: first, whether role-complementarity could be established, for example, by the individual constituting a particularly ‘interesting case’ (*ibid.*, pp. 92-93) that permitted the demonstration of valued professional skills from doctors and nurses; second, whether the individual was a ‘regular visitor’ (*ibid*, p. 96) and attended EDs ‘time and time again’ (*ibid.*, p. 102). In these latter cases another distinction was drawn between the individual who took a single overdose, who might have ‘really tried to commit suicide (for whom there is some respect) and the rest (viewed as immature calls for attention)’ (*ibid*, p. 100). With this new bifurcation, Jeffery was signifying the relevance of self-harm’s relation to suicide and repetition noted above as a

variation in the binary coding of the 'good' and 'bad patient' and in the statistical facts on self-harm in EDs. Whilst single acts of self-harm tended to be labelled as 'genuinely' suicidal and classified as 'good', repetitive acts of self-harm tended to be labelled as 'attention-seeking' and subsequently classified as 'bad'.

This binary coding remains relevant today. In terms of EDs it has been usefully historicized in the work of Cresswell and Karimova (2010) and Millard (2015). This research emphasised that self-harm's binary code both pre-dates and post-dates Jeffrey's ethnography and indicated that the contemporary moral code of self-harm in EDs should be dated from the *Suicide Act* of 1961, which both decriminalised non-fatal self-harm and then re-institutionalised it within a health-based rather than crime-based system of values. Cresswell and Karimova also supplemented Jeffery's analysis of punishment via an exploration of service user's personal testimonies of treatment in EDs (for example, in Pembroke, [ed], 1994). Whereas Jeffery was concerned exclusively with self-poisoning in EDs, service user organisations such as the National Self-Harm Network (NSHN, 2000) showed how it applied to self-injury too, especially in the form of the suturing of self-inflicted wounds without adequate pain relief. These concerns were re-affirmed in the work of Inckle (2010).

There are two further additions to be made to Jeffery's analysis to bring it up to date. These concern the written rules components of the moral code.

NICE. The rules surrounding self-harm have been expanded by the introduction of Clinical Guideline 16 (cg16) by NICE in 2004. Entitled, 'short term management and prevention of recurrence', cg16 signifies two related developments: first, the mandatory provision of a 'psycho-social assessment' (NICE, 2004, pp. 25-27) for individuals who self-harm and are brought to EDs, thus emphasising the linkage between self-harm, suicide and repetition via an assessment of suicide risk; and second, the growth of liaison psychiatry attached to EDs and tasked with the implementation of cg16 (see Royal College of Psychiatrists, 2013). From the

perspective of moral codes, liaison psychiatry introduces another layer of moral evaluation into the assessment of individuals who self-harm and therefore a new assessment of the legitimate attribution of the sick role. Whilst there is no simple correspondence between self-harm and psychiatric diagnoses – and self-harm itself has not until recently constituted a formal diagnostic category (see Zetterqvist, 2015) – it is correlated as a symptom with such diagnoses. In EDs the most frequently associated diagnoses are depression and anxiety (Hawton *et al*, 2013) although the 'highly contested' conditions of personality disorder and dual diagnosis (Menkes and Bendelow, 2014, p.78) – the 'co-morbidity' (Hawton *et al*, 2013) of a mental health condition with substance abuse - are also significant for the moral evaluation of self-harm in EDs. As Menkes and Bendelow (2014, p. 72) noted, dual diagnosis and personality disorder are 'contested' conditions because they are sometimes perceived as forms of 'social deviance' which are 'less "legitimate" than other mental disorders'.

Section 136. The use of section 136 (s136) of the *Mental Health Act* (1983) (MHA), entitled '[m]entally disordered persons found in public places', is increasingly significant for both EDs and liaison psychiatry. S136 empowers the police to remove a person who 'appears…to be suffering from a mental disorder and to be in immediate need of care and control' and take them to a 'place of safety' (POS) where a MHA assessment is performed. Several recent studies have indicated that a primary reason for the police's use of s136 occurs when the detainee has self-harmed or is at risk of self-harm and/or suicide (Bendelow *et al*, 2016, p. 13; Thomas and Forrester-Jones, 2018; Zisman and O' Brien, 2015, p. 217).

The duration of s136 detention is 24 hours, reduced from 72 hours in 2017 by the *Policing and Crime Act* (2017). The assessment may result in a longer detention under the civil sections of the MHA, such as section 2 for up to 28 days, but it may also result in discharge from the s136 and does so in the majority of cases (see Pugh and Laidlaw, 2016). Controversy has surrounded the increase in the police's employment of s136 in recent years – rising from 5, 495 detentions

in 2005/06 to 22, 965 in 2015/16 (NHS Digital, 2016, pp. 14-15) - and the use of police cells as a POS (Care Quality Commission, 2014). One response to this has been to reduce the use of prison cells and replace them with 'health-based places of safety' (HBPOS) of which one is EDs. Additionally, EDs may also be used for emergency medical treatment for s136 detainees in cases of self-harm (Royal College of Emergency Medicine, 2017). As a result of these developments, more s136 detainees are arriving at EDs for treatment and MHA assessments and the reduced time-scale of 24 hours has increased the pressure on liaison psychiatry and related staff such as Approved Mental Health Professionals (AMHPs) (Mental Health Act, 2007, s.18-20) and psychiatrists (Mental Health Act, 1983, s12).

Bendelow's recent research (Menkes and Bendelow, 2014; Bendelow *et al*, 2016; Bendelow *et al*, 2019) has highlighted the dilemmas involved in these short-term detentions. One such dilemma concerns the moral evaluation of the individual on s136 and the legitimacy of the attribution of the sick role. Whereas for the police the legitimacy of the sick role where the individual is considered at risk of self-harm and/or suicide seems unproblematic, from the perspective of liaison psychiatry, s136 detainees may be assessed as having no diagnosable mental illness so that the attribution of the sick role may be denied on the grounds that other classifications of social deviance may seem more appropriate. In these latter cases the specific moral evaluations of individuals with personality disorders and/or dual diagnosis is a major point of contention. These controversies are explored further in the penultimate section below, this time engaging some of the deeper aspects of moral code theory outlined in section 2, especially the concept of moral relativism.

5. Moral Relativism and Self-Harm in Contemporary EDs

The bifurcation into a binary coding of 'good patient' and 'bad patient' remains a central feature of the moral code of self-harm in EDs. But that coding does not function in the same

way and its variations have different manifestations when applied, on the one hand, to NICE's cg16 and, on the other hand, to s136. One key to understanding these differences is to be found in the moral relativism of moral code theory and its classification of social deviance.

The fact is that the contemporary moral code oscillates between different classifications of deviance. Developments such as cg16 and the growth of liaison psychiatry tend to endorse a positive moral evaluation of the individual who self-harms and, therefore, the legitimate attribution of the sick role. There are three reasons for this. First, there is the correlation noted above between self-harm in EDs and the psychiatric diagnoses of anxiety and depression, revealed through the psychosocial assessment which cg16 mandates. In these cases the role-complementarity characteristic of the smooth functioning of sick role and the therapeutic role potentially applies because as Hawton *et al* noted the diagnosis of depression and anxiety facilitates 'appropriate psychological and/or pharmacological treatments' (2013, p. 828). Second, cg16 also supports the moral code's progressive components because for the first time it officially acknowledged service user perspectives and the existence of punishment. This was manifested in cg16's concession that 'the experience of care for people who self-harm is often unacceptable' (NICE, 2004, p, 7). Such recognition was partly the result of the activism of the service user-led National Self-Harm Network (NSHN, 2000). Third, the growth of liaison psychiatry also seems progressive because of the influence of service user perspectives on psychiatric nurse education (McKeown *et al*, 2012) and because, as has been noted in systematic reviews, the relatively positive attitudes demonstrated towards individuals who self-harm by psychiatrically trained rather than general medical staff (Cleaver, 2014, p. 75; Saunders et al, 2012, p. 213). These factors emphasise the legitimate attribution of the sick role and progressive relationships of solidarity between individuals who self-harm and health care staff. They oscillate towards the 'good patient' pole of the binary code and a classification of self-harm as a mental health condition.

By contrast, Bendelow's research into the application of s136 reveals a different oscillation. From the point of view of the police, s136 represents a manifestation of social deviance that has to be classified and controlled. Given that considerable numbers of such situations involve acts or risks of self-harm, the police are resistant to labelling these as immoral or criminal, partly because no breach of the criminal law may have occurred, and partly because they feel compassion for someone they intuitively classify as 'mentally ill'. As Bendelow *et al* (2016) showed, the police acknowledge their lack of mental health expertise but they place their trust, instead, in their commitment to public protection. 'S136 is widely used as a suicide prevention measure,' Bendelow *et al* concluded (*ibid*., p. 16). When using this measure, the police employ a simple binary coding of individual behaviour into 'Suicidal' and 'Not suicidal':

> 'Detentions were coded as "Suicidal" if the records had stated the person was detained because of concerns that they intended to end their life, had taken an overdose etc…'Not suicidal' was coded if the person was detained for making threats of violence to others or where detention was on the basis of apparent psychotic symptoms or similar concerns' (*ibid*.).

Again, this coding oscillates towards the 'good patient' pole of the binary code via the attribution of the sick role to the s136 detainee. However, the simplicity of the suicidal/not suicidal coding contrasts with the complexity of the classificatory dilemma faced by liaison psychiatry, AMHPs and psychiatrists when the s136 detainee is brought to an ED. This is because complexities of dual diagnosis and personality disorder enter the classificatory situation. As Hawton et al noted (2013), although the most common diagnoses of individuals who self-harm in EDs are depression and anxiety, they are followed by alcohol misuse and personality disorder. Dual diagnosis in this context, refers to those cases where the mental health condition of the detainee is accompanied by intoxication by either alcohol and/or illegal drugs; whilst personality disorder refers to that class of 'highly contested' conditions formerly

known as ‘psychopathy’ (see Manning, 2000). Given that one aspect of intoxication and personality disorder is that the individual may be deemed to have broken one of the unwritten rules of the sick role – specifically, that in order to be classified as ‘genuinely ill’ they must not be held responsible for their condition – the moral evaluations of mental health professionals becomes entwined with the hostile labelling of the individual who self-harms, originally identified by Jeffery in 1979. As previously noted, repetition is a significant component of this labelling process and it remains significant for s136 detainees because not only are some of them repeating the act or the risk of self-harm but some are also multiple s136 detainees. In Bendelow *et als* research in Sussex they found that ‘a third of detentions were attributable to 142 people who were detained more than once that year’ (2016, p. 13) and these findings have been confirmed elsewhere in England (Zisman and O’Brien, 2015; Thomas and Forrester-Jones, 2018). The consequences of repetition for the individual who self-harms or is considered at risk of self-harm and/or suicide is a potential amalgamation of types of social deviance: specifically, an amalgamation of moral evaluations which stress immorality and criminality, oscillating, therefore, towards the ‘bad patient’ pole of the binary code. Bendelow *et al* (2016, p. 4) quote one psychiatrist as opining that the ‘police use 136 because it’s easier than arresting drunks.’ Although it would be a mistake to think that this is the perspective of all mental health professionals, it does sum up an attitude that is, to a certain extent, ‘entrenched’ (*ibid*.). The moral code oscillates, then, between classifications of mental health conditions, immorality and criminality – between the ‘good patient’ and ‘bad patient’ poles of the binary code - sometimes legitimising the detainee through the first, sometimes delegitimising him through an amalgamation of the second and the third. Again, this oscillation signifies the relativism of the moral code of self-harm in EDs. Depending on the diagnosis and depending on the individual behaviours of detainees, the police, and mental health professionals, individuals may be either classified as having a mental health condition, immoral and/or criminal.

It may seem a misnomer to talk about criminality with respect to self-harm in 2018, especially since it was decriminalised by the *Suicide Act* (1961) nearly 60 years ago. But criminality has re-entered the moral code with the surge in s136 detentions since the millennium where it re-appeared as contrasting classificatory choices. For the police, it re-appeared as a choice between labelling social deviance in public places as either a crime or a mental health condition, with the latter emerging as a preferred option. For mental health professionals it re-appeared as a choice in EDs about differential diagnosis: the presence of a mental health condition in addition to suicide risk may result in the attribution of the sick role in the form of a civil section of the MHA, or in cases of less severe risk, a psycho-social assessment that also leads to the attribution of the sick role. But where criminality specifically re-appeared is with personality disorders and dual diagnosis where repetitive self-harm is accompanied by intoxication. In these cases, the individual who self-harms or is at risk of self-harm may be deemed responsible for whatever crime or misdemeanour accompanied their detention and the mental health condition may be considered merely a diagnostic smokescreen for a categorically immoral and/or criminal act.

One final question is raised by the moral relativism of moral codes. What are the oscillating classifications of social deviance actually relative *to*? What is the definition of moral relativism? The answer has four elements. First, moral codes are *historically* relative. They oscillate over time and the characteristic feature of the moral code of self-harm from the *Suicide Act* (1961) onwards is the oscillation from a predominantly crime-based to a predominantly health-based classification - but without immorality or criminality ever disappearing. Second, moral codes are *culturally* relative in that attitudes to human behaviours such as suicide and self-harm vary from society to society in terms of the symbolic classifications used to depict them and the prohibitions that surround them (see Chaney, 2019). Third, moral codes are relative to *mental health conditions*. The moral code of self-harm is not the same as the moral

code of schizophrenia, for example, although it interacts in significant ways with other mental health conditions, such as personality disorders. Fourth, moral codes are *institutionally* relative. Health institutions such as EDs demonstrate different attitudes to self-harm than the police – but if the institutional focus was altered again to analyse, for example, women's prisons where there are also high rates of self-harm, the moral code that surrounds it would look different again (see Cresswell *et al*, 2018). Moral codes are institutionally specific.

6. Conclusion

Yet, although moral codes are specific and relative, they still possess a generality that is common to them. Moral code theory is a way of analysing the social reactions of healthcare institutions to mental health conditions. Durkheim, Parsons, and Alexander are its theoretical roots. Moral codes have middle-range theoretical components which consist of rules, labelling, the sick role, punishments and progressive components; they also have deeper theoretical elements which stress the moral ontology of society and the fact that they are expressed in symbolic, often binary, codes. This article has analysed the specific moral code that surrounds the mental health condition of self-harm and has focussed on emergency departments (EDs) in the NHS in England. Self-harm is the object of specific patterns of rules, labelling, the attribution and denial of the sick role, punishments and progressive components. The most significant binary code that has been attached to it has been the bifurcation between the 'good patient' and the 'bad patient'. Social reactions to self-harm are morally relative to the extent that self-harm has been, and still is, variously classified as a mental health condition, immoral, and/or criminal.

References

Alexander, J. and Smith, P. (2002) The strong program in cultural theory: Elements of a structural hermeneutics. In: J.H. Turner (ed.) The Handbook of Sociological Theory. New York: Kluwer Academic/Plenum Publishers, pp. 135-150.

Alexander, J. (2002) On the social construction of moral universals: The Holocaust from war crime to trauma drama. European Journal of Social Theory 5(1): 5-85.

Alexander, J. (2006) The Meanings of Social Life: A Cultural Sociology. Oxford: Oxford University Press.

Barr, B, Taylor-Robinson, D, Scott-Samuel, A, McKee, M. and Stuckler, D (2012). Suicides associated with the 2008-10 economic recession in England: time trend analysis. British Medical Journal [online], doi: https://doi.org/10.1136/bmj.e5142.

Bendelow, G., Warrington, C. and Jones, A. (2016) Section 136 in Sussex. Brighton: University of Brighton.

Bendelow, G, Warrington, C, Jones, A-M and Markham, S. (2019) Police detentions of the mentally ill in public places: a multi-method approach to reveal the complexity of factors in section 136 use of the Mental Health Act in Sussex. Medicine, Science and the Law, 59: 95-103.

Busfield, J. (1996) Men, Women and Madness: Understanding Gender and Mental Disorder. Basingstoke: Macmillan.

Care Quality Commission (2014) A safer place to be? Findings from our survey of health-based places of safety for people detained under section 136 of the Mental Health Act. Newcastle-upon-Tyne: Care Quality Commission.

Carroll, R, Metcalfe, C. and Gunnell, D. (2014) Hospital presenting self-harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. Plos One 9(2): 1-9.

Chaney, S. (2019) Psyche on the skin: A history of self-harm. London: Reaktion Books

Charmaz, K. and Rosenfeld, D. (2009) Chronic illnesss. In: W. Cockerham (ed*), The new Blackwell companion to medical sociology.* Chichester: Wiley/Blackwell, pp. 312-334.

Cleaver, K. (2014) Attitudes of emergency care staff towards young people who self-harm: A scoping review. International Emergency Nursing 22: 52-61.

Clements, C, Turnbull, P, Hawton, K, Geulayov, G, Waters, K, Ness, J, Townsend, E, Khundakar, K. and Kapur, N. (2016) Rates of self-harm presenting to general hospitals: a comparison of data from the Multicentre Study of Self-Harm in England and Hospital Episode Statistics. British Medical Journal Open, doi: e009749.

Cresswell, M. and Karimova, Z. (2010). Self-harm and medicine's moral code: a historical perspective, 1950–2000. Ethical Human Psychology and Psychiatry 12(2): 158-175.

Cresswell, M, Karimova, Z. and Ward, J. (2018) Women, Self-Harm, and the Moral Code of the Prison. Ethical Human Psychology and Psychiatry 20(1): 27-42.

Durkheim, E. (1926) The Elementary Forms of the Religious Life. London: Allen & Unwin.

Durkheim, E. (1964) The Rules of Sociological Method. New York: The Free Press.

Durkheim, E. (1966) Suicide. New York: The Free Press.

Durkheim, E. (1992) Two laws of penal functioning. In: M. Gane (ed.) The radical sociology of Durkheim and Mauss. London: Routledge, pp. 21-49.

Geulayov, G, Kapur, N, Turnbull, P, Clements, C, Waters, K, Ness, J, Townsend, E. and Hawton, K. (2016) Epidemiology and trends in non-fatal self-harm in three centres in England, 2000–2012: findings from the Multicentre Study of Self-harm in England. British Medical Journal Open, doi: e010538.

Gerhardt, U. (1989) Ideas about Illness: An Intellectual History of Medical Sociology. Basingstoke: Macmillan.

Hawton, K, Bergen, H, Geulayov, G, Waters, K, Ness, J, Cooper, J, and Kapur, N. (2016). Impact of the recent recession on self-harm: longitudinal ecological and patient-level investigation from the Multicentre Study of Self-harm in England. Journal of Affective Disorders 191: 132-138.

HM Government (2012) Preventing Suicide in England: A Cross-Governmental Outcomes Strategy to Save Lives. London: Department of Health.

Inckle, K. (2010) Flesh Wounds: New Ways of Understanding Self-Injury. Monmouth: PCCS Books.

Jeffery, R. (1979). Normal rubbish: deviant patients in casualty departments. Sociology of Health and Illness 1(1): 90-108.

Menkes, D.and Bendelow, G. (2014) Diagnosing vulnerability and "dangerousness": police use of Section 136 in England and Wales. Journal of Public Mental Health 13(2): 70-82.

Merton, R. (1949) Social Theory and Social Structure. New York: Simon & Schuster.

Manning, N. (2000) Psychiatric diagnosis under conditions of uncertainty: personality disorder, science and professional legitimacy. Sociology of Health & Illness 22(5): 621-639.

McKeown, M, Malihi-Shoja, L, Hogarth, R, Jones, F, Holt, K, Sullivan, P, Lunt, J, Vella, J, Hough, G, Rawcliffe, L, Mather, M, and CIT. (2012) The value of involvement from the perspective of service users and carers engaged in practitioner education: Not just a cash nexus. Nurse Education Today 32: 178-184.

Mental Health Act (1983) London: The Stationary Office.

Mental Health Act (2007) London: The Stationary Office.

Millard, C. (2015) A history of self-harm in Britain: a genealogy of cutting and overdosing. London: Palgrave/Macmillan.

National Institute for Health and Care Excellence. (2004). Self-harm in over 8s: Short term management and prevention of recurrence. Manchester, UK: NICE.

National Institute for Health and Care Excellence. (2011). Self-harm in over 8s: Long-term management. Manchester, UK: NICE.

NHS Digital (2016) Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Uses of the Mental Health Act: Annual Statistics, 2015/16. London: Health and Social Care Information Centre.

National Self-Harm Network (2000) Cutting The Risk: Self-harm, Self-care and Risk Reduction. London: NSHN.

Parsons, T. (1951) The Social System. London: Routledge and Kegan Paul.

Parsons, T. (1964) Social Structure and Personality. New York: The Free Press.

Parsons, T. (1975) The Sick Role and the Role of the Physician Reconsidered. The Milbank Memorial Fund Quarterly, Health and Society 53(3): 257-278.

Policing and Crime Act (2017) London: The Stationary Office.

Pugh, D. and Laidlaw, J. (2016) Sections 135 and 136: Running a health-based place of safety in Gloucestershire. Medicine, Science and the Law 56(2): 99-106.

Royal College of Emergency Medicine (2017) A brief guide to section 136 for emergency departments. London: Royal College of Emergency Medicine.

Royal College of Psychiatrists (2013) Liaison psychiatry for every acute hospital, College Report, CR183. London: Royal College of Psychiatrists.

Saunders, K, Hawton, K, Fortune, S.and Farrell, S. (2012) Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. Journal of Affective Disorders 139: 205-216.

Shilling, C. (2002) Culture, the 'sick role' and the consumption of health. British Journal of Sociology 53(4): 621-638.

Suicide Act (1961) Chapter 60 9 and 10 Eliz 2.

Thomas, A. and Forrester-Jones, R. (2018) Understanding the Changing Patterns of Behaviour Leading to Increased Detentions by the Police under Section 136 of the Mental Health Act 1983. Policing: A Journal of Policy and Practice [online]. Available at: https://academic.oup.com/policing/advance-article/doi/10.1093/police/pay011/4930653. [Accessed 10 November, 2018].

Varul, M. (2010) Talcott Parsons, the sick role, and chronic illness. Body and Society 16(2): 72–94.

Zetterqvist, M. (2015) The DSM-5 diagnosis of nonsuicidal self-injury disorder: a review of the empirical literature. Child and Adolescent Psychiatry and Mental Health 9(31): 1-13.

Zisman, S. and O' Brien, A. (2015) A retrospective cohort study describing six months of admissions under Section 136 of the Mental Health Act; the problem of alcohol misuse. Medicine, Science and the Law 55(3): 216-222.

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